JANET NAPOLITANO
GOVERNOR

STATE OF ARIZONA
ARIZONA DEPARTMENT OF VETERANS SERVICES
ARIZONA STATE VETERAN HOME
ADULT DAY HEALTH CARE CENTER
4141 N. 3RD STREET
PHOENIX, ARIZONA 85012
(602) 248-1572 FAX (602) 351-6899

PATRICK CHORPENNING
DIRECTOR

I am happy you are interested in the Arizona Department of Veterans' Services, Adult Day Health Care program. All of the staff are committed to serving adults who are in need of socialization, nursing supervision, therapeutic recreation and rehabilitation during the day.

Attached is the application that must be completed to begin the admission process. There is a $ 25 application fee. Please make the check out to the Arizona State Veteran Home, Adult Day Health Care Center. You will also find the medical report that the doctor must complete before admission can occur.

Applications may be mailed to: V. Ann Ferguson, Manager
Adult Day Health Care Center
4141 N. 3rd Street
Phoenix, Arizona 85012-1832

Please contact me at 602-248-1572 or our social services representative Mika Kondo at 602-263-1830 if you have any questions, for program fee information or to arrange for a tour of the facility and interview.

Sincerely,

V. Ann Ferguson, RN, FNP-C
Program Manager

ADULT DAY HEALTH CARE APPLICATION

Date_____

Name_____
Last First Middle Phone

Address_____
Street City State ZIP

Date of Birth_____ Age_____ Marital Status_____

Social Security Number_____ Medicare Number_____

Source of Referral_____ Religion_____

Previous occupation(s)_____ Years Retired_____

PERSON(S) TO CONTACT IN CASE OF EMERGENCY:

Name Relationship Address Phone

1._____

2._____

3._____

ATTENDING AND ALTERNATE MEDICAL CARE PROVIDER:

Name_____ Phone _____

Address_____
Street City State ZIP

Name_____ Phone _____

Address_____
Street City State ZIP

CHOICE OF HOSPITAL: _____

Applicant Name: _____

MEDICAL DIAGNOSES:

_____

_____

_____

ALLERGIES: _____

DIETARY RESTRICTIONS: _____

MEDICATIONS: (List all of the medications the applicant is currently taking)

	Medication name	Dosage	Frequency	When taken
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				

Applicant's Name: _____

PHYSICAL FUNCTIONING (CHECK APPROPRIATE DESCRIPTION)

Ambulation/Walking Ability:

_____ Unassisted _____ Needs Assistance

_____ Uses Appliance ____ Cane _____ Walker _____ Crutches ____ Wheel Chair

Vision:

_____ Good _____Wears glasses _____ Contacts _____ Limited _____ Blind

Hearing:

_____ Good _____ Wears Aid – right, left, both _____ Hard of Hearing

Assistance needed in the Following Areas:

_____ Ambulation _____ Toileting _____ Feeding _____ Reasoning

_____ Other (describe) _____

MENTAL FUNCTIONING:

_____ Alert _____ Confused _____ Forgetful _____ Periods of Confusion

Briefly describe applicant's mental status: _____

_____

SOCIAL AND EMOTIONAL FUNCTIONING:

Describe how the applicant relates to other people: _____

_____

Activities preferred: (Includes special interests, skills and hobbies – past and present)

_____

_____

_____

Applicant's Name: _____

TRANSPORTATION:

_____ Family or individual can provide _____ Needs assistance with transportation

SCHEDULE PREFERRED:

_____ Monday _____ Tuesday _____ Wednesday _____Thursday _____ Friday

Hours preferred: _____

FINANCIAL INFORMATION:

Monthly Income: _____

Sources of monthly income: _____

Primary Health Insurance Provider: _____

Address: _____
Street City State ZIP

Policy Number: _____ Group Number: _____

Secondary Health Insurance Provider: _____

Address: _____
Street City State ZIP

Policy Number: _____ Group Number: _____

Name of person completing application: _____

Relationship to applicant: _____

Signature: _____ Date: _____

Adult Day Health Care - Physician Health Review

Patient's Name_____ Date of Birth: _____ Age:_____

Height: _____ Weight: _____ Blood Pressure: _____

Allergies (if any):_____

General Physical Condition: Excellent _____ Good _____ Fair _____ Poor _____

Cognition Level:

Oriented: _____ Moderate Confusion: _____

Mild Confusion: _____ Severe Confusion: _____

Current Diagnosis: _____

_____

_____

Any remarkable findings of most recent EKG: _____

_____

TB SKIN TEST OR CHEST X-RAY REQUIRED WITHIN SIX MONTHS PRIOR TO DATE OF ADMISSION:

PPD Date: _____ Results: Negative_____ Positive_____

Chest X-ray Date: _____ Results: _____

Current Medications:

Medication:	Dosage:	Frequency:	For what condition:

Permission for patient to administer own medication: yes _____ no _____

Diet: Regular_____ Diabetic_____ Other_____

Activity Orders (specify self, one or two person assist, wheel chair, walker, cane or crutches):

Ambulation: _____

Toileting: _____

Transferring: _____

Eating: _____

Dental: _____

Respiratory: _____

Visual: _____

Auditory: _____

Restrictions/ Limitations, Other: _____

_____

Standing Orders:

Tylenol 650 mg. po q4-6 hrs prn discomfort, headache or fever yes_____ no_____

Tums or Mylanta tabs ii or liquid 30 cc po prn indigestion yes_____ no_____

Imodium AD prn diarrhea per label instructions yes_____ no_____

Antibiotic ointment to minor wounds, cuts, abrasions yes_____ no_____

Ibuprofen 400 mg po q4-6 hrs prn pain inflammation yes_____ no_____

Hydrocortisone cream for relief of inflammation or itching yes_____ no_____

A & D ointment to chapped, chaffed skin prn yes_____ no_____

Zinc Oxide to chapped, chaffed skin prn yes_____ no_____

Physician's Signature: _____ **Date**: _____

Print Name: _____

Address: _____

Phone: _____ Fax: _____

I hereby authorize release of this information relevant to this request:

_____

Patient/Responsible Party **Relationship to Patient** **Date**